



CANNON BUILDING
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STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION
BOARD OF MEDICAL PRACTICE

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV

APPLICATION FOR LICENSURE AS AN ACUPUNCTURE PRACTITIONER

TYPE OF APPLICATION

- Show type of application you are choosing to file (check one):
 - ☐ Original Licensure
 - ☐ Licensure by Reciprocity – I hold a current, active license in another state which has licensing requirements equal to or exceeding the requirements for licensure. **Attach copies of the state licensing/practice statutes and regulations pertaining to the practice of acupuncture from the jurisdiction where you are licensed.**
- Are you *currently* practicing acupuncture in Delaware? Yes ☐ No ☐ If yes, continue with Question 3. If no, skip to Question 4.
- Were you practicing acupuncture in Delaware during the 12-month period 6/27/2007 - 6/26/2008 (the date of enactment of the law governing the practice of acupuncture in the State of Delaware)? Yes ☐ No ☐ **If yes, submit evidence of your practice during 6/27/2007- 6/26/2008. If you were employed, provide Form W-2. If you were self-employed, provide Schedule C of your tax return, business license, or other similar documentation acceptable to the Council.**

IDENTIFYING AND CONTACT INFORMATION

- Full Name: _____
Last First Middle
- Address: _____
City State Zip
- Telephone: _____ 7. Email: _____
daytime or cell fax
- Date of Birth: _____
- Have you been issued a U.S. Social Security Number? Yes ☐ No ☐
 - If yes, enter your SSN: _____
 - If no, you must file a *Request for Exemption from Social Security Number Requirement*.

EDUCATION INFORMATION

- Enter the following information about your acupuncture practitioner education:

SCHOOL/TRAINING	LOCATION	DATES ATTENDED		DEGREE

11. Have you successfully completed a course or passed an examination in clean needle technique? Yes ☐ No ☐ **If yes, attach course certificate. If CNT was completed before 1990 as part of the NCCA (predecessor of the NCCAOM) exam in acupuncture, the NCCA certification in acupuncture (achieved in 1990 or before) will be accepted in lieu of the above mentioned course certificate.**
12. Is English your second language? Yes ☐ No ☐ **If yes, submit proof that you passed the Test of English as a Foreign Language (TOEFL) with a minimum score of 550, or any other method as provided in the rules and regulations.**

INFORMATION ABOUT LICENSURE & PRACTICE

13. Have you ever sought or been granted an acupuncture practitioner license under another name? Yes ☐ No ☐ If yes, enter other name(s) used: _____
14. Are any disciplinary actions or complaints pending against you before any body that regulates the practice of acupuncture? Yes ☐ No ☐ If yes, identify where the action is pending and describe the complaint/action. Include the anticipated date of resolution, if known: _____

15. Have you ever had an acupuncture practitioner license denied, revoked, suspended or limited or placed on probation? Yes ☐ No ☐ If yes, explain circumstances and outcome. **Attach a copy of the disciplinary order:** _____

16. Do you now hold, or have you ever held, a license as an acupuncture practitioner in any State, District of Columbia, or US territory? Yes ☐ No ☐ If yes, enter information about your licenses:

STATE	LICENSE NUMBER	EXPIRATION DATE

Arrange for a "letter of good standing" to be sent to the Board directly from each State where you hold, or have ever held, an acupuncture practitioner license.

HEALTH AND DISABILITY

17. Within the two years preceding this application, have you had a physical or mental disability which could reasonably be thought to interfere with your practice as an acupuncture practitioner, including use or abuse of dangerous or addicting substances? Yes ☐ No ☐
 - If yes, explain on a separate sheet and attach to this application.**
 - If no, skip to Question 21.
18. Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? Yes ☐ No ☐ **If yes, explain on a separate sheet and attach to this application.**
19. Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting or the manner in which you have chosen to practice? Yes ☐ No ☐ **If yes, explain on a separate sheet and attach to this application.**

LEGAL AND BEHAVIORAL

20. Have you ever been convicted of or entered a plea of guilty or *nolo contendere* (no contest) to any felony, misdemeanor or any other criminal offense, including any offense for which you have received a pardon, in any jurisdiction? Yes ☐ No ☐ If yes, explain below. Include any other name(s) used:

21. Have you ever been disciplined by a healthcare facility or any entity governing acupuncture licensure? Yes ☐ No ☐ If yes, explain on a separate sheet and attach to this application. Include a copy of the disciplinary action.

To assure consideration of your license application at the next Council meeting, the Division must receive all of these items no later than 4:30 PM ten full working days before the Council's meeting date:

- Completed, signed and notarized application form
- Fee payment
- All required supporting documentation.

Applications that are not complete within six (6) months of filing may be considered abandoned and discarded. The Board office will attempt to notify you before disposing of an abandoned application.

Please note: When your application is complete, please allow 4-8 weeks to receive your permanent license (whether or not a temporary license has been issued).

AFFIDAVIT

I, _____, swear that I am the person who executed this application; that the statements contained on this application are true in every respect; that I have not suppressed or withheld information that might affect this application; and I will abide by the laws and the ethical standards of this profession; and that I have read and understand this statement.

I further understand that by filing this application for an Acupuncture Practitioner in the State of Delaware, I hereby authorize and consent to have an investigation conducted to determine my professional qualifications, to determine if I have previously engaged in unprofessional conduct as defined in 24 *Del. C.* §1731 or the Board of Medical Practice and Council's Rules and Regulations and to determine that I am physically and mentally capable of engaging in the practice of acupuncture with safety to the public.

I authorize the Council of the Board of Medical Practice and request every person, hospital, clinic, community, governmental agency (local, state, federal or foreign), court, association, institution or other organization having control of any documents, records or other information pertaining to me, to furnish to the Delaware Board of Medical Practice any such information, including document, records regarding charges or complaints filed against me, formal or informal, pending or closed, other pertinent data and to permit the Delaware Board of Medical Practice or any of its agents or representatives to inspect and make copies of such documents, records, and other information, in connection with this application, subsequent licensure or practice thereunder.

APPLICANT SIGNATURE: _____ Date: _____

Sworn to before me and subscribed in my presence this _____ day of _____ 20____,
County of _____ State of _____

My commission expires: _____
Notary Public

SEAL

**APPLICATIONS THAT ARE UNSIGNED, NOT NOTARIZED, INCOMPLETE OR SUBMITTED WITHOUT THE
REQUIRED PROCESSING FEE WILL NOT BE ACCEPTED.**